were excluded unless specific reference was made to mental problems.

The files of 81 families involving 145 children were examined. Mental health support was needed in 40 of 82 (48%) families involving 44 parents. Services were availed from community psychiatric nurses (5%), community mental health workers (5%), counsellors (7%), general practitioners (18%), forensic psychiatrists (20%) and psychiatrists (23%).

Evidence of information sharing between social services and other health professionals was seen in 11 (61%) cases. Information was shared orally, through reports and attendance at conferences by the Child and Adolescent Mental Health Services, community psychiatric nurses and mental health workers. In one case, a psychiatrist's report was provided. Oral information sharing limited to one or two sentences occurred through second parties in three cases. In one case, the social worker contacted the designated paediatrician who obtained information from the psychiatrist.

Our audit again shows that although there are existing structures, they are not effectively integrated. This may reflect absence of protocols that work across agencies. Information sharing was not predictable, consistent or adequate. Some sharing of information occurred at the conferences. A conference may have been used to get professionals together to share information. Poor prioritisation of child protection by adult mental health services might have contributed to a lack of active seeking of information by social services. A wide range of services apart from forensic psychiatry were available locally in Coventry. Reports from forensic psychiatrists were uniformly unavailable to the conferences. Specialisation, difference in location and management structures might have contributed to this. Resource constraints may have affected decision making.

Subsequent to our audit, we nominated a liaison mental health professional between adult mental health and children's services. Through training, we encourage social workers to actively invite other agencies to share information in a variety of ways. General practitioners' invitations to conferences now provide optional ways of information sharing and include a reminder about the importance of sharing information in child protection matters. The three interagency study days were strengthened to include clear protocols for professionals.

In families in which parents with mental health problems look after children, agencies need to communicate freely and effectively. In the face of such communication, it is likely that ''child in need'' issues will not progress to child protection.

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Author's response

Barry Zuckerman's letter describes the ''Reach Out and Read'' programme as an essential part of child health promotion. As literacy is probably one of the most health-protective skills we can equip children and young people with, we would agree with him. In the UK, Bookstart was initiated in 1992, and by 2001 it had a reach of over one million children. Through the Sure Start centres in England, a scheme exists which provides every 7–9 month old living in disadvantaged circumstances, usually through the home visitor (health visitor), a pack including two board books, nursery rhymes, advice on sharing books, information on libraries and story time community events. In one area, the 9-month hearing test was organised in a local library to help capture infants at an early stage. The scheme is funded centrally by the Department of Education and Skills and the Department of Work and Pensions. Books are available in 16 languages. The scheme has been extended to 18-month olds and 3-year olds. An important point raised by Dr Zuckerman is the awareness of general practitioners and paediatricians regarding this scheme and linking parents to it.

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Re: From health surveillance to health promotion: the changing focus in preventive children's service

Blair and Hall's article[1] provides an important justification from a shift in child health surveillance to child health promotion including the important role of other disciplines and agencies. This information is relevant to the US as it is to the UK. However, I would like to bring to their attention for inclusion into their recommendations an important evidence-based activity that promotes children's development and pre-emergent literacy. Reach Out and Read (ROR) is a programme practised almost entirely in the US, in which primary care paediatricians give advice to parents about developmentally appropriate strategies to read to their child and give low-income children a book to take home at each health supervision visit from age 6 months to 6 years.[2] This effort is now practised in more than 3000 clinics and practices throughout the US and reaches more than three million children. The published evidence from multiple studies shows that parents are more likely to read to their children, literacy oriented activities are increased and, most importantly, children's language development is increased by 4–8 points compared with children not exposed to ROR. Next to immunisations, ROR is the only evidence-based health promotion strategy in primary care for children. Not only is this strategy effective, but given its cost of £2.80 (€4.20; $5.50) per child/per year it is exceptionally cost effective; children start school with at least 10 books in their home for less than £15 (€2; $30).

I realise that paediatricians infrequently provide primary care in the UK but suggest that an effort like ROR should be part of health promotion activities, whether practised by paediatricians or general practioners to benefit high-risk, low-income children in the UK.

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Non-adherence to tuberculosis treatment

Marais *et al*[1] reported on a prospective community-based study into adherence of monochemotherapy with isoniazid in preventing tuberculosis in the suburbs of Cape Town, South Africa. They studied children who were less than 5 years of age and who had household contact with an adult pulmonary tuberculosis index case. The main evaluation was the children's prescription collection at various intervals from the start of chemotherapy to the end at 6 months. They found that only 20% of the children completed $\leqslant$5 months of unsupervised chemotherapy. The ethical underpinning and structure of this study is questioned. It was clear that during the early stages—that is, at 1 and 2 months of the study—a number of children were not compliant with the therapy. At this stage, the guardians were not questioned regarding the reasons for non-attendance, nor educated on the importance of compliance. Furthermore, no arrangements were made for ensuring subsequent compliance. Instead, the children were simply monitored for further non-compliance, and were ''allowed'' to develop tuberculosis; which is what six of them did. One would assume that normal professional practice would be that whenever any non-compliers are located, a strict form of supervision or directly observed therapy be instigated—that is, before any disease progression occurred. Also, the authors

did not investigate the reasons for non-compliance. It is not possible that the guardians were too sick with their pulmonary tuberculosis or HIV (not mentioned in the study, but assumed to be endemic in the suburbs of South Africa) to bring their children regularly to the clinics. On the basis of anecdotal experience of non-compliance, we use dual therapy with rifampicin and isoniazid. As soon as any non-compliers are located, intensive supervised treatment or directly observed therapy is instigated.

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Chronic intestinal ischaemia and Hirschsprung's disease

The prolonged carriage of *Clostridium difficile* in Hirschsprung's disease reported in this study[1] raises the possibility that Hirschsprung's might indeed be a product of intestinal ischaemia that develops in utero and might persist thereafter as chronic intestinal ischaemia, possibly because of persistent vascular abnormalities.[2]

Chronic ileal ischaemia seems to be the primary cause of pouchitis and the septic complications and anastomotic leaks complicating restorative proctocolectomy of ulcerative colitis.[3] Anaerobes proliferate in a newly constructed pouch,[4] and when pouchitis develops, these may include *C difficile*. This is consistent with the proposal that *C difficile* might be a marker of ischaemic colitis.[5] Pseudomembranous enterocolitis and haemorrhagic necrotising enterocolitis complicating Hirschsprung's might also be products of intestinal ischaemia.[6]

Objective evidence of chronic intestinal ischaemia might only be apparent in a stress test, notably gastric exercise tonometry in the adult.[7] If, however, histopathic hypoxia is a contributing factor, as is likely with any inflammatory disease superimposed on the Hirschsprung's, it should be evident from tonometric measurements performed at rest. It would be advisable to include the intramucosal pH as an end point in performing tonometry[8]; the partial pressure of the carbon dioxide-gap may not be increased in these circumstances.[9] From our experience with chronic gastric ischaemia, enteral feeding even with cold water might be conveniently used as a stress test in infants. This may not be without risk in the critically ill in whom histotoxic or cytopathic hypoxia might be present.[10 11]

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Trisomy 13 is associated with anorectal malformations

Babies with trisomy 13 (Patau's syndrome) have a median survival of 2.5 days, with only 5% surviving beyond 6 months. There are three cases of trisomy 13 with anorectal malformation in the English literature; a partial trisomy of chromosome 13q and 20p,[1] a mosaic form (46,XX,t(13q13q)/46,XX,−13,+r(13))[2] of trisomy 13 and a third case in which the form of trisomy 13 was not described.[3] We report a case of full trisomy 13 with an unusual anorectal malformation.

A boy delivered at 36 weeks' gestation had antenatal scans showing a cleft lip and a large ventricular septal defect with an over-riding aorta. He was below the third centile for weight and head circumference. He had a small occiput with occipital and parietal scalp defects, micro-ophthalmia, a cleft lip and palate, fisted hands, rocker-bottom feet, micropenis, an impalpable right testis and an imperforate anus. Echocardiography showed a patent ductus arteriosus and coarctation of the descending aorta in addition to a ventricular septal defect and an over-riding aorta. Fluorescent in situ hybridisation and karyotype analysis confirmed trisomy 13 with a Robertsonian translocation of the extra chromosome 13 to chromosome 14.

On day 2, he had increasing abdominal distension and pain. A plain abdominal film showed a hugely distended colon with no gas beyond the pelvic brim (fig 1). Importantly, the gas pattern in the sigmoid colon was limited to the left iliac fossa, whereas distension of the sigmoid typically displaces the sigmoid colon to the right in imperforate anus.

Despite the short life expectancy, we performed a colostomy under general anaesthesia for the palliative relief of intestinal obstruction at 64 h. At laparotomy, his distended sigmoid colon had no mesentery, and it was difficult to mobilise. This is unusual. A flush colostomy was therefore formed in the anterior wall of the sigmoid colon. He was comfortable postoperatively, but developed increasing respiratory distress and died at 84 h. No postmortem examination was performed, and we do not know whether there was a fistula to the urinary tract.

Interestingly, in a study of 1992 patients with anorectal malformation, 5% had trisomy 21 but none had trisomy 13.[4] Of the 1992 patients, 238 had no fistula and 40% of patients without fistulas had trisomy 21. In a smaller study of 103 patients with anorectal malformation, one had trisomy 13.[3] Trisomy 13 with a coexisting anorectal malformation could be a chance occurrence. Alternatively, a genuine association between trisomy 13 and anorectal malformations exists, and the unusual anorectal anomaly in this case supports this hypothesis.

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